Arkansas Department of Human Services (DHS)
Division of County Operations (DCO)

FOR OFFICE USE ONLY

		REGISTER #	APPLICATION DT	COUNTY	CAT.	ADULTS	CHILD	WORKER #	WORKER NAME	MRT	SMN	KEY DATE	OP. INT
REG	1												
	2												

		WORKER #	DENIAL DATE	REASON	SAVINGS	TYPE	CATEGORY	CN	KEY DATE	OP. INT
DEN	1									
	2									

APPLICATION FOR FAMILY MEDICAID ASSISTANCE

If you need this material in a different format, such as large print, contact your DHS county office.

Please answer all questions as completely and as accurately as possible. If you do not understand a question the caseworker you speak with will help you. If you do not have enough space for your answer, attach another sheet of paper to this application.

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	BIRTH DATE	RACE	SEX

MEDICARE NUMBER	LAST GRADE COMPLETED	MARITAL STATUS	TELEPHONE NUMBER WHERE YOU CAN BE REACHED

STREET ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE

Please list everyone in your home (including yourself) and complete each space by their name:

Social Security Number	Name Last	Name First	Birthdate	Race	Sex	Relationship to you	Is this person a US Citizen	Is this person a Legal Alien	Is this person a Other	FOR OFFICE USE ONLY MRT	FOR OFFICE USE ONLY IN APP

INCOME: DOES ANYONE IN YOUR HOUSEHOLD HAVE INCOME FROM THE FOLLOWING?

Source of Income			Amount Before Any Deductions	How Often Received	Name of Person(s) Receiving	Medical Benefits Insurance	
Employment/work	Yes ☐	No ☐				Yes ☐	No ☐
Employment/work	Yes ☐	No ☐				Yes ☐	No ☐
Farming	Yes ☐	No ☐				Yes ☐	No ☐
Self-employment	Yes ☐	No ☐				Yes ☐	No ☐
Rental of Property	Yes ☐	No ☐				Yes ☐	No ☐
Retirement Benefits	Yes ☐	No ☐				Yes ☐	No ☐
Social Security Benefits	Yes ☐	No ☐				Yes ☐	No ☐
Social Security Benefits	Yes ☐	No ☐				Yes ☐	No ☐
Supplemental Security Income (SSI)	Yes ☐	No ☐				Yes ☐	No ☐
Supplemental Security Income (SSI)	Yes ☐	No ☐				Yes ☐	No ☐
Transitional Employment Assistance (TEA)	Yes ☐	No ☐				Yes ☐	No ☐
Veteran's Benefit or Other Pensions	Yes ☐	No ☐				Yes ☐	No ☐
Servicemen's Allotments	Yes ☐	No ☐				Yes ☐	No ☐
Job Corps Allotments	Yes ☐	No ☐				Yes ☐	No ☐
Child Support/Alimony	Yes ☐	No ☐				Yes ☐	No ☐
Contributions from Friends or Relatives	Yes ☐	No ☐				Yes ☐	No ☐
Unemployment Benefits	Yes ☐	No ☐				Yes ☐	No ☐
Worker's Compensation	Yes ☐	No ☐				Yes ☐	No ☐
Student Loans, Grants	Yes ☐	No ☐				Yes ☐	No ☐
Roomers or Boarders	Yes ☐	No ☐				Yes ☐	No ☐
Insurance	Yes ☐	No ☐				Yes ☐	No ☐
Other (Such as Part-time work, babysitting, etc.)	Yes ☐	No ☐				Yes ☐	No ☐

Do you expect a change in any of the above? _____ If yes, what and when? _____

Has anyone in your home worked in the last 6 months who is not working now? If yes, list their name, the last month/year in which the person worked, and the place they worked. _____

How have you been meeting your expenses for the past 6 months? _____

RESOURCES: DOES ANYONE IN YOUR HOME HAVE, OR IS THEIR NAME ON, ANY OF THE FOLLOWING?

		Amount	Where	Name of Person(s)
Cash on hand	Yes ☐ No ☐			
Checking Account	Yes ☐ No ☐			
Savings Account	Yes ☐ No ☐			
Money in a Christmas Club	Yes ☐ No ☐			
Money in a Credit Union	Yes ☐ No ☐			
Life Insurance	Yes ☐ No ☐			
Property other than your home	Yes ☐ No ☐			
Burial Funds/Insurance	Yes ☐ No ☐			
Mortgages	Yes ☐ No ☐			
Stocks	Yes ☐ No ☐			
Bonds	Yes ☐ No ☐			
Burial Plot/Crypt	Yes ☐ No ☐			
Other (Trust Fund, C.D., IRA, Promissory Note, Mutual Fund, etc.)	Yes ☐ No ☐			

		Make & Year	Amount Owed	Who Owns
Cars	Yes ☐ No ☐			
Trucks	Yes ☐ No ☐			
Trailers, Boats, Motorcycles, ATV's, etc.	Yes ☐ No ☐			
Other (Farm Equipment, Machinery, Tools, Livestock, etc.)	Yes ☐ No ☐			

Family Planning - I may be eligible for Family Planning Services and:

I want Family Planning Services ☐ Yes ☐ No
I want more information about Family Planning Services ☐ Yes ☐ No
Someone in my household is pregnant ☐ Yes ☐ No
I would like Family Planning Services when the pregnancy ends. ☐ Yes ☐ No

Child Health Services (Health Checkups)
The health checkup program has been explained to me and:

☐ I do want this service for all eligible persons
☐ I do want this service for only the following persons: _____
☐ I do not want this service.

Does anyone have any unpaid medical expenses in the past 3 months? ☐ Yes ☐ No

Does a child in your home have a chronic illness or disability (special health care needs)? ☐ Yes ☐ No If yes, list name(s) _____

Health Insurance

Does anyone in your household now have health insurance of any kind? ☐ Yes ☐ No
If yes, please name household member (s) and insurance company: _____

Has anyone in your household had health insurance, other than Medicaid, in the last 12 months? ☐ Yes ☐ No
If yes, please name household member (s) and insurance company, and state why this insurance is no longer available:

READ THIS PAGE CAREFULLY BEFORE YOU SIGN THIS APPLICATION.

I understand that I must help establish my eligibility by providing as much information as I can about my circumstances.

I authorize DCO to obtain information from other state agencies and other sources to confirm the accuracy of my statements.

I understand Social Security Numbers (SSNs) will be used in a computer match to detect and prevent duplicate participation. SSNs are also used in a match through the State Income and Eligibility Verification System to secure wage, unearned income and benefit information from the Social Security Administration, Employment Security Division, and Internal Revenue Service. Information received may be verified through collateral contact when discrepancies are found by DHS and may affect eligibility or level of benefits.

I understand that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, handicap, religion, national origin, or political belief.

I may request a hearing from DHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.

I agree to notify the DHS county office within 10 days if I or any of my dependents cease to live in my home, if I move, or if any other changes occur in my circumstances.

I authorize DHS to examine all records of mine and/or records of those who receive or have received Medicaid benefits through me, to investigate whether or not any person has committed Medicaid fraud, or for use in any legal, administrative or judicial proceeding.

ASSIGNMENT OF MEDICAL SUPPORT. I authorize any holder of medical or other information about me to release information needed for a Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS for my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of a Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source which may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent of medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

ASSIGNMENT OF SUPPORT - OFFICE OF CHILD SUPPORT ENFORCEMENT
As a condition of eligibility for Medicaid, each applicant or recipient must cooperate with the Office of Child Support Enforcement (OCSE) in establishing paternity and obtaining medical support for each child who has a parent absent from the home. All other OCSE services, including collection of child support payments from the absent parent, will be provided unless OCSE is notified by me in writing that I do not want these services.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT. If I receive benefits to which I am not entitled because I withheld information or provided inaccurate information, such assistance will be subject to recovery by DCO, any assistance I receive in the future may be reduced to recover this overpayment, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Signature of Applicant	Date Signed
Witness, if signed by mark	Signature of Protective Payee or Authorized Representative
Address of Witness	Signature of Family Support Specialist